STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #2	445143	A. BUILDING _____ B. WING _____	C 09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT ROCKWOOD, THE	5580 ROANE STATE HWY ROCKWOOD, TN 37854

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F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, review of facility policy, and review of facility documentation the facility failed to fully investigate and document results on the grievance log. The findings included: Interview with the Director of Nursing (DON) on September 18, 2012, at 11:10 a.m., in the Chaplain Office, revealed a family member had given the DON a list of six Certified Nurse Aide (CNA) names and informed the DON the CNA's were using illegal drugs. Further Interview at this time with the DON confirmed the facility requested the employees on the list provide a urine specimen for reasonable suspicion. Continued interview with the DON on September 18, 2012, at 11:10 a.m., confirmed three of the employees had been terminated related to the drug screening, either with positive results or with fraudulant sample submission. Review of the grievance log revealed the family concern had not been documented on the Resident/Visitor/Grievance/Complaint Log. Review of the facility policy dated effective	F 166	**Disclaimer:** Signature Healthcare of Rockwood does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil of criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Jarfi	Administrator	10/17/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 12-2010, Investigating a Grievance or Complaint revealed " ...It is the intent of this facility that all grievances ...be investigated ...all grievances will be documented ...the grievance ...and the corrective action will be documented ...on the grievance/complaint log ..." Interview with the Administrator on September 18, 2012, at 2:20 p.m., in the Chaplain Office, confirmed the facility failed to fully investigate the family concern of employees using illegal drugs and to document the results on the grievance log. complaint 30356	F 166	**F 166 Right to Prompt Efforts To Resolve Grievances** The facility will fully investigate and document results on the grievance log. **Residents affected:** No residents were named as being affected by the deficient practice. **Residents potentially affected:** Residents of the facility have the potential to be affected by this deficient practice. The Social Services Director was inserviced on 9/21/12 by the Administrator on the importance of assuring that all grievances are placed on the Grievance Log.	10/20/12
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview the facility failed to prevent misappropriation of narcotic pain medications for one resident (#1) of nine residents reviewed. The findings included: Resident #1 was admitted to the facility on February 12, 2008, and readmitted on October	F 224	**Systemic measures:** The Social Services Director was inserviced by the Administrator on 9/21/12 on the importance of assuring that all grievances are placed on the Grievance Log. Grievances will be reviewed in the daily morning Whiteboard meeting, which includes, at a minimum, the following team members: ADM, DON, ADON's, SSD, and any other team members as directed by the ADM/DON. Grievance Logs will be reviewed by the Administrator weekly for a period of 3 months for compliance and monthly thereafter. Any needed corrections will be made immediately. **Monitoring measures:** Grievance Logs will be reviewed by the Administrator weekly for a period of 3 months for compliance and monthly thereafter. Any needed corrections will be	

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F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observartion, review of facility documentation and interview the facility failed to post the correct nurse staffing data.	F 356	made immediately. The results of these weekly reviews will be reported in the monthly QA committee meeting, which includes, at a minimum, the following team members: Medical Director, ADM, DON, DM, SSD, and any other team members and/or consultants as directed by the ADM/DON x 3 months. **F 224 Prohibit Mistreatment/Neglect/Misappropriation** The facility will prevent misappropriation of narcotic pain medications.. **Residents affected:** Resident #1oxycontin 15 mg was discontinued on 9/11/12. Resident was reimbursed for missing narcotics and police was notified of missing narcotics. **Residents potentially affected:** Residents of the facility have the potential to be affected by the deficient practice. 100% audit of all residents narcotics, to include any discontinued narcotics, was completed with no deficient practice noted. **Systemic measures:** Education/Training was provided by the Adm/DON on 9/21/12 to 100% of Nursing Admin on the process for missing narcotics as follows: 1. Immediately audit to ensure the security of all medication/controlled substances. 2. Preserve all evidence such as controlled substance sign in sheets, containers etc.	10/20/12

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F 224	Continued From page 2 25, 2008, with diagnoses including Alzheimer's Disease, Anxiety, and Fractured Arm. Medical record review of a physician's telephone order dated September 11, 2012, revealed "...Oxycodone (narcotic pain medication) 15 mg (milligram) d/c (discontinue) due to non use..." Review of the medical record revealed the resident also had an order for Oxycodone 10 mg. as needed for pain and the resident was receiving the 10 mg. when requested. Observation and interview with Licensed Practical Nurse (LPN) #2 on September 18, 2012, at 9:25 a.m., in the West Wing hallway, of the controlled substance record revealed no count sheet available for Oxycodone 15 mg. and the medication was not available on the medication cart. Review of the controlled substance record revealed a count sheet was in place and all medications accounted for the Oxycodone 10 mg. Observation and interview with the Director of Nursing (DON) on September 18, 2012, at 2:10 p.m., in the DON office, confirmed the oxycodone 15 mg. had not been listed on the destruction log or had been destroyed by the facility. Review of pharmacy logs revealed on September 3, 2012 the resident had received forty-two Oxycodone 15 mg. The facility was unaware the forty-two Oxycodone 15 mg. tablets were unaccounted for. Interview with the DON on September 18, 2012, at 3:00 p.m., in the Chaplain Office, confirmed the facility failed to prevent the misappropriation of pain medications for one resident (#1). complaint 30356	F 224	3. Request that all staff who had or could have had access to medication cart remain in facility. 4. Obtain drug tests on all staff who had or could have had access to the medications. 5. Audit 100% narcotics to ensure that all are reconciled accurately a. Review all MARs for administration of pain meds b. Cross walk the MAR records, pain assessments, the narcotic sign out to ensure compliance of documentation and use of Clinical Monitoring Sheet. 6. Contact pharmacy for review of controlled substances to ensure system integrity for due diligence. 7. Be sure the process for administration & tracking narcotics is being followed a. Review policy & procedure with all licensed staff b. Ensure that 2 nurses are counting and signing controlled substances. i. Audit controlled substance count sheets to ensure signatures are completed & there are no gaps ii. Nurses are signing in & out per policy c. Is there evidence that nurses are counting narcotics between each shift d. Ensure the off going nurse is reading from the controlled substance sheets and the oncoming nurse is counting the medications on the cart calling out the numbers then both verify both the actual medication as well as the count sheet.	

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F 356	Continued From page 4 The findings included: Observation of the nurse staffing on September 19, 2012, at 11:10 a.m., revealed no Registered Nurses, eight Licensed Practical Nurses, and eleven Certified Nurse Aides currently on duty. Observation and review of the posted nurse staffing data and interview with the Corporate Nurse, on September 19, 2012, at 12:10 p.m., in the front lobby, revealed the staff posted was four Registered Nurses, eight Licensed Practical Nurses, and eleven Certified Nurse Aides. The Corporate Nurse confirmed the posted nurse staffing was not accurate.	F 356	e. Re-educate all licensed nursing staff on the P&P for administration & management of controlled substances. Conduct random audits for compliance. 8. Conduct interviews and clinical assessments of all patients with orders as requested for pain: A. Have they experienced pain, if so, at what level? B. Is it effectively managed? C. Are we following our pain policy? D. Is pain monitored & documented each shift E. Are we using the visual analog clinical monitoring pain sheet for all PRN pain meds being administrated? F. Are we using the back of the MAR and/or scheduled template for scheduled narcotics? G. Are we attempting and documenting non-pharmacologic approaches to pain relief? H. Are we clinically re evaluating a residents increased use of PRN pain medication to see if it needs to be scheduled or medication changed? I. Are results of pain medication or other interventions for relief documented? J. Notify Medical Director of incident K. Report to appropriate authorities L. Police must also be notified M. Conduct education for all staff on Abuse & Neglect education and focus on misappropriation.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		

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F 431	Continued From page 5 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation, review of facility policy and procedures and interview, the facility failed to establish a system of disposition of all controlled drugs and determine drug records are in order. The findings included: Observation with Licensed Practical Nurse (LPN) #1 on September 18, 2012, at 9:12 a.m., on the East Wing, revealed Licensed Practical Nurse (LPN) #1 administering medications and confirmed a narcotic count had been completed at the beginning of the shift with the nurse going off duty. Review of the Narcotic Count Sheet revealed on September 18, 2012, the sheet had not been signed by the nurses as performed/completed. Observation and interview of a random narcotic count at this time revealed: Resident #7 had an order for Lorazepam (anti anxiety) 0.5 mg (milligram) the count sheet	F 431	Interview residents regarding residents regarding lost items and their overall treatment. Etc. N. Ask administrator to be sure resident is not billed for missing medications. O. Develop a Process Improvement Plan to monitor controlled substances, staff compliance with policy for controlled substance and pain. Audit for compliance and report to Quality Assurance/Performance Improvement Committee monthly Education/training was provided to 100% of licensed staff on medication administration-narcotic/controlled medication accountability and wasting of controlled medications and medication administration – medication destruction (Process for discontinued narcotics) Please see attachment. ADON's and/or Charge nurses will review all narcotics/narcotic count sheets on daily basis and report findings during morning clinical meeting. **Monitoring measures:** Narcotic count sheets will be reviewed by the Director of Nursing weekly for a period of 3 months for compliance and monthly thereafter. Any needed corrections will be made immediately. The results of these weekly reviews will be reported in the monthly QA committee meeting x 3 months. **F 356 Posted Nurse Staffing Information**	10/20/12

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F 431	Continued From page 6 revealed forty-one available and LPN #1 confirmed only forty available; Resident #6 had an order for Lorazepam 0.5 mg the count sheet revealed sixty and LPN #1 confirmed only fifty-eight available; Resident #8 had an order for Lorazepam 0.5 mg the count sheet revealed twenty-seven and LPN #1 confirmed only twenty-six available; Resident #9 had an order for Fentanyl (pain) Patch 75 mcg (micrograms) the count sheet revealed one available and LPN #1 confirmed none were available. Further interview with LPN #1 and the Director of Nursing (DON) at this time confirmed the narcotics had been given to the residents but had not been signed out at the time the medicaitons were administered. Review of facility policy effective December 2010, revealed "...at each shift change...a physical inventory of all controlled medication is conducted by two licensed nurses...and is documented on the controlled substance accountability record...if a medication is removed, the controlled substance accountability record must reflect..." Interview with the DON on September 18, 2012, at 9:20 a.m., in the East Wing hallway, confirmed the facility failed to follow the policy for narcotic/controlled medication.	F 431	The facility will post correct nurse staffing data. **Residents affected:** No residents were named as being affected by the deficient practice. **Residents potentially affected:** Residents of the facility have the potential to be affected by this deficient practice. The proper method of documenting nurse staffing was reviewed with the Director of Nursing, ADONs and the staffing coordinator. **Systemic measures:** The proper method of documenting nurse staffing was reviewed with the Director of Nursing, ADONs and the staffing coordinator. Previous days' posted staffing sheets will be brought to the daily morning Stand-up meeting for review. **Monitoring measures:** Previous days' posted staffing sheets will be brought to the daily morning Stand-up meeting for review. The results of these reviews will be reported in the monthly QA committee meeting x 3 months. **F 431 Drug Records, Label/Store Drugs & Biologicals** The facility will establish a system of disposition of all controlled drugs and determine drug records are in order. **Residents affected:** Resident #6,7,8,9 had received their	10/20/12